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(5) Lessons Learned, Hq & Hq Det, 68th Medical Group
APO San Francisco 96243

(8) (11) 14 May 1966

SUBJECT: (9) Operational Report [redacted] for Quarterly Period Ending 31 April 1966. (U)

TO: The Assistant Chief of Staff for Force Development
Department of The Army
Washington, D.C. 20310

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1. (U) This is the initial report of Headquarters and Headquarters Detachment, 68th Medical Group which arrived in The Republic of Vietnam (RVN) on 7 February 1966 and became operational on 1 March 1966. (12) 12 p.

SECTION I

SIGNIFICANT ORGANIZATIONAL ACTIVITIES

2. (U) Overseas movement. a. The Headquarters and Headquarters Detachment, 68th Medical Group, was alerted for overseas assignment on 27 October 1965. The next few weeks were used to complete POR training, receive filler personnel, and fill equipment shortages. The main body, consisting of the Executive Officer and consisting of 6 officers, 1 warrant officer, and 27 enlisted men departed Fort Sands, Maryland, on 17 January 1966. The advance party consisting of the Commanding Officer and the [illegible] departed by air on 21 January 1966. The advance party arrived in RVN on 21 January 1966 and the main body on 6 February 1966 and proceeded to its present location at Long Binh. After one week of adjusting to the [illegible] climate conditions, an extensive program was initiated to prepare the [illegible] site for occupancy. Materials were secured for the construction of tent flooring and showers. All labor for construction, with the exception of latrine construction, was on a self-help basis. Personnel worked long, arduous hours in accomplishing this tremendous task. Throughout this entire period of preparation and construction, morale remained at a high peak.

On 1 March 1966, the [illegible] became operational, providing command, control, and administrative support to thirty-eight subordinate units.

b. Upon deployment the unit was at full strength with 7 officers, 1 warrant officer and 28 enlisted men. No major problem existed in that never filler enlisted personnel were inexperienced in their jobs, however through on-the-job training, they have progressed to a degree of satisfactory proficiency.

Upon becoming operational the 68th Medical Group Personnel section consisted of the Personnel Officer, Personnel Staff NCO, and a Personnel Management Specialist. This section was processing all personnel actions and consolidating all reports from subordinate units.

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Communications and a lack of local command directives and guidance posed a serious problem. With the move of the 93th Med Bn to the Long Binh area, a consolidated personnel section was established, utilizing clerks from all the units whose records were maintained. This consolidation greatly improved the efficiency of personnel management within the Group and insured more rapid processing of personnel actions and consolidation of reports.

b. Space in the Long Binh area (near Bien Hoa, RVN) coordinates YT 045095, South Viet Nam Map 1:50,000, series L701, was assigned to this unit. The area, formerly a rubber plantation, was in process of being cleared when the main body arrived.

c. The HHD, 93th Medical Battalion, a unit which was to be assigned to this Group, was commanded by a Lieutenant Colonel senior to the Group commander. As a result, the two officers switched assignments on 1 February 1966 on order of the Commanding General, 1st Logistical Command, the next senior headquarters. Later, however, when the new Group Commander returned to CONUS on emergency leave (subsequently on TDY), the CO of the 93th Medical Battalion also became CO of the Group and held both positions until 12 April 1966 when a new Battalion Commander was designated. The final result was the Group Commander who brought the unit to RVN was back in his original assignment.

d. The advance party coordinated plans for the arrival of the main body, obtained what few local directives which were available from higher headquarters, requisitioned station-type property, obtained personal items of equipment for the on-coming main body, and arranged for logistical support, including engineer and signal.

e. After arrival of the main body, self-help material (e. g. lumber, nails, sandbags, engineer stakes) with which to floor all tents and complete other construction requirements were requisitioned. The land was ready for occupancy on or about 15 February 1966. The unit immediately began constructing flooring and a shower unit. The engineers constructed the latrine. Since that time, work has continued, even to this day, to improve operating and living conditions.

f. The Group became operational on 1 March 1966. However, there were some actions the Group took even before that date. For example, in the midst of establishing ourselves we were required to locate and request real estate, submit requests for construction, and requests for equipment above TOE (e. g. generators, air conditioners) for 14 medical units due to arrive in RVN within the next 120 days. Difficulty was experienced in attempting to conduct day-to-day operations while at the same time establishing the liable layout of the Group headquarters and performing housekeeping functions such as sanitation, water distribution, and unpacking supplies and equipment. The solution was to work longer hours (even days a week at 100% strength.

3(b)(1)(a). a. The mission of this unit is to provide a combination of Field Army level and Command Zone level medical service in III and IV Corps tactical zones (RVN military boundaries) to U.S. and Free World Military Assistance Forces (FWMAF).

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In addition, and until the 4th Medical Brigade became operational in May 1966, this Group was also responsible for inter-zonal medical services such as veterinary, dental, and preventive medicine for US and FWMAF in all of RVN.

b. There is no separate Field Army level medical service in RVN. U.S. combat and combat support units located in III and IV corps tactical zones are under Field Force Vietnam II located in Long Binh. This is equivalent to a U.S. Corps type headquarters. The 60th Medical Group supports these forces with Field Army and Corps level medical service and maintains liaison with that headquarters for that purpose.

c. The 60th Medical Group provides aeromedical evacuation from unit and division level medical elements to evacuation and surgical hospitals under the Group. It also provides area medical service to combat service support units in III and IV Corps tactical zones.

4.(U) Organization. a. Upon arrival in-country this Group was assigned to the 1st Logistical Command. Assigned to the Group on 1 March 1966 were thirty-eight (38) units consisting of teams, hospitals, companies, and a medical battalion, HHD. To reduce the span of control units were further assigned by this headquarters to other units so that the following were directly commanded and controlled by this headquarters:

HHD 58th Medical Battalion
4th Medical Detachment (JA)
932nd Medical Detachment (AI)
20th Preventive Medicine Unit (Service)(Field)
3rd Field Hospital
3rd Surgical Hospital (Mobile Army)
Medical Company (Air Ambulance) (Prov)
345th Medical Detachment (MA)
93rd Evacuation Hospital

b. The main body of the 17th Field Hospital and the 36th Evacuation Hospital arrived in-country on 10 March 1966. The 17th Field Hospital, with one hospitalization unit, assumed operation of the Navy hospital in Saigon. The 36th Evacuation Hospital moved into partially completed buildings (Butler Type) at Vung Tau. Both units became operational on 1 April 1966. The 17th Field opened with 100 beds. The 36th Evacuation Hospital, because of incomplete construction, opened with 50 beds, but later in April, as construction progressed, expanded to 200 beds. It will expand to its full capability of 400 beds as construction, water, and power permits.

c. The 17th Field Hospital was assigned to this headquarters on 1 April, 1966. While no orders have been issued to date, the 36th Evacuation Hospital will be assigned to this Group.

d. On 31 March, 1966 the 60th Medical Group was relieved from assignment to the 1st Logistical Command and assigned to the Medical Brigade (Provisional), an interim organization until the complete 44th Medical Brigade arrived in-country.

e. The 4th Medical Detachment (JA), 20th Preventive Medicine Unit (Service)(Field) and the 932nd Medical Detachment (AI) were relieved from assignment to this Group and were assigned to the Medical Brigade (Provisional) on 1 April, 1966. Reason for this is that these units provide inter-zonal (both 43rd Medical Group and 60th Medical Group areas) medical service support. This latest action reduced the Group's span of control from eleven to eight major units.

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f. The Medical Company (Air Ambulance)(Provisional) a command and control unit for four Medical Detachments (AA) (Helicopter Ambulance) was reorganized on 1 April, 1966 to provide it 2 officers and 6 enlisted men. Heretofore, it consisted of 1 officer and 1 enlisted man which were not sufficient to provide proper command and control of four AA detachments.

g. On 19 April 1966 the Headquarters and Headquarters Detachment, 58th Medical Battalion, a subordinate unit, relocated from Saigon to Long Binh and occupied cleared land next to this Headquarters. Purpose of this move was to make room in real estate-scarce Saigon for the Medical Brigade.

5. (C) Operations. a. The 3rd Surgical Hospital, located at Bien Hoa, RVN, was deployed on 26 February 1966 to Ban Me Thout located in II Corps Tactical Zone to support Operation [illegible]. The hospital was placed under operational control of the 43rd Medical Group for the operation. Problems associated with this deployment: The hospital was "well-fixed" in semi-permanent building at Bien Hoa, was using mostly station-type equipment, and in general was not "mobile" as a Surgical Hospital (Mobile Army) should be. As a result, a large amount of effort had to be expended to bring the unit up to its authorized equipment allowances. This equipment had to be laterally transferred from other sources. Because of the area of operations it was going into, male nurses had to be transferred in to replace the female nurses. Although the hospital is designed to be 100% mobile, it had less than 60% of its authorized cargo vehicles, since the unit was directed to laterally transfer six of its 2½ ton cargo trucks on 19 Oct, 1965. These shortages were obtained by issue or lateral transfer. An additional three, 2½ ton cargo trucks, over TOE authorization, were also loaned to the unit to transport additional expendable supplies above that authorized in the unit assembly.

b. This headquarters was tasked by the 1st Logistical Command to support Operation [illegible], a search and destroy operation conducted by elements of the 1st Infantry Division in Phuoc Tuy province commencing on or about 1 April, 1966. The problems associated with this operation: the 93th Evacuation Hospital at Vung Tau, which was tasked to provide hospitalization for the operation, just (21 March) received its equipment and the hospital was in the midst of construction and was not yet operational. By around-the-clock work, it managed to establish 50 beds to meet the beginning date of the operation. Plans were that surface evacuation was to be provided from Vung Tau. There is no ambulance unit in Vung Tau except for the 2 ambulances assigned to a PX dispensary. Therefore, 4 ambulances had to be airlifted to Vung Tau from resources in Saigon. An officer and 8 enlisted men and a ton truck with radio were airlifted to Vung Tau for the purpose of providing an operational team to handle air medical evacuation support.

c. Operation [illegible], a search and destroy operation conducted by elements of the 173rd [illegible] in mid-April 1966, was supported by this Group. One aeromedical helicopter ambulance element at the Artillery Base at [illegible] near Phuoc Vinh (YT 1065). Hospitalization was provided by the 93rd Evacuation Hospital, 3rd Surgical Hospital, and 36th Field Hospital.

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d. In order to support 1st Infantry Division elements (2 Brigades) in Operation [illegible], which commenced on 24 April, 1966, this headquarters provided a 2 - table surgical capability made up of personnel from the 3rd Surgical Hospital, 93rd Evacuation Hospital, and the 3rd Field Hospital. The team consisted of 14 persons including two surgeons, two general medical officers, and two anesthetists. The team was commanded by Major Peter Downs, Commanding Officer, 3rd Surgical Hospital. This provisional team is being tried here for the first time. An after-action report will be submitted by Major Downs in order to provide a basis for evaluation of this concept. The operation was based at TAY NINH. This headquarters also provided aeromedical evacuation from the operational area to our hospitals.

e. The aforementioned operations are mentioned because they required more than the normal planning for support. Routine operations supported by this Group have not been included here.

6. (U) Malaria. a. Because of the large number of malaria admissions in the II Corps tactical zone it was necessary to transfer, several times, 50 to 100 cases to 68th Medical Group hospitals located in III and IV Corps tactical zones. As a result of the decreasing number of available beds, action was taken on 27 April, 1966 to expand the number of operating beds. A survey made on that date indicated that the following medical treatment facilities could expand:

(1) 93rd Evacuation Hospital - 144 beds by moving assigned personnel in semi-permanent buildings to tents, or, 100 beds could be made available by double bunking assigned personnel. This was so ordered. On 28 April this hospital made 70 beds available; 30 more were established on 29 April.

(2) 36th Evacuation Hospital: Fifty beds could be made available on 28 April by decreasing the floor space per existing bed. An additional 50 beds could be made available on or about 1 May by utilizing the partially completed buildings on the hospital site. It was so ordered, 50 beds immediately and 50 more beds on 1 May. If still more beds are required, and if approved by the CO Vung Tau Sub-area, the chapel at Vung Tau could expand to 50 beds.

(3) 610th Medical Company (Clr). This unit has one platoon at Phu Loi operating 40 beds but capable of operating 60 beds. It was ordered that sufficient personnel be moved to Long Binh to set up 40 beds without reducing the 40 beds now at Phu Loi.

(4) 17th Field Hospital. This unit can expand by setting-up 25 cots in its present space. If necessary, and with very uncomfortable crowding, 20 more cots could be set up. Also, as an extreme emergency measure 60 cots could be set up under awning space outside the building but heat and flies would be a distinct disadvantage. No action was ordered at the time.

(5) 3rd Field Hospital. This hospital could set up 5 tents, 6p large, each accommodating 16 patients in the spaces between buildings. This would provide 80 beds. No action was ordered at the time.

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(6) 3rd Surgical Hospital. This hospital could set up 4 tents, GP, large, each accomodating 16 patients in the area around the hospital. With nurses and medical specialists working 12 hours a day, the personnel shortage could be met. No action ordered at the time.

b. (1) Related to the problem of a heavy admission rate caused by malaria, a new treatment regimen was prescribed by the Director of Medical Services, Hq, 1st Logistical Command for Plasmodium Falciparum Malaria cases. This regimen consists of combined oral treatment with quinine and daraprim as indicated: Day 1 to 14: quinine sulfate, oral 650mg every 8 hours for 14 days (total dose 26.8 grams). Day 1 to 3: daraprim, oral 25mg every 8 hours for 3 days (total dose daraprim 225mg). Intravenous quinine can be used at the discretion of the attending medical officer.

(2) On day 7 of the combined malaria therapy regimen, each patient will be started on DDS (Diaminodiphenylsulfone). One tablet (25mg) will be given daily thereafter for a period of 28 days.

(3) All patients who are clinically stable and without parasitemia may be discharged to duty after completion of quinine and daraprim therapy o/a 15th day of treatment. At the time of discharge sufficient tablets of DDS will be given each patient to insure completion of the 28 day course of DDS therapy. The remaining period of time that DDS must be taken after discharge will be specified in writing and given to the patient upon discharge from the hospital.

(4) The above discharge procedure is also applicable to all current convalescent malaria patients except those under a protocol evaluating a specific malaria treatment regimen.

(5) The objective of this treatment program is to return individuals to a duty status in approximately two weeks with full recognition that less than 5% may relapse.

(6) At the time of discharge, a notification will be expeditiously sent to the CO of each patient. This notice will state "(name, rank, SN, and organization) is convalescing from malaria. He was started on a 28 day course of DDS on(date). It is necessary for him to take one DDS tablet daily through (date). Request you take necessary action to insure his daily taking of the DDS which has been given him. The necessity of this daily dose cannot be over-emphasized."

7.(4) Inspections. a. The following units were inspected by this headquarters timed to provide them a command inspection and a preliminary to the annual I.G. inspection conducted by CG, 1st Logistical Command:

3rd Field Hospital - 8 April 1966
93rd Evacuation Hospital - 19 April 1966
HHD 50th Medical Battalion - 26 April 1966

b. The method of inspection by this headquarters follows this procedure:

(1) The unit is provided a check list, several days in advance, for each area to be inspected.

(2) The entire inspection team meets with the staff of the inspected unit.

(3) The Group Commander outlines the purpose of the inspection emphasizing the Group's desire to assist the unit being inspected.

(4) A time is selected for the exit briefing.

(5) Each inspector pairs off with his counterpart of the inspeced unit.

(6) After the inspection, a copy of the each completed check list is left with the unit and one copy retained by the inspector.

(7) At the exit briefing the unit inspected is informed of the major deficiencies uncovered.

(8) Follow-up is made later by each inspector to assure himself that deficiencies uncovered were corrected.

8. (U) Physical Security. a. The threat of the security of US personnel, equipment and installations in South Vietnam is continuous. The threat may be in the form of terrorist activities, civil disturbances or natural disasters. This wide variety of hazards demand the maximum physical security measures possible under existing conditions.

b. This headquarters is vigorously pursuing a physical security program aimed at reaching every individual within the medical command of the 68th Medical Group. This program is being implemented by the development of sound and realistic physical security measures. This is accomplished by:

(1) Designating an officer on orders at each medical unit or installation as physical security officer.

(2) By establishing and maintaining liaison with designated physical security officers of higher and lower headquarters.

(3) By conducting frequent physical security surveys of all medical units under this headquarters. These surveys are designed to evaluate the adequacy of existing safeguards, to identify deficiencies and to determine and recommend corrective action.

(4) By developing, reviewing and upating all physical security SOP's, local security annex's, disaster annex's and DR/RC security annex's.

(5) By familiarizing all personnel with the provisions of each plan, conducting specialized training and by conducting a minimum of one practice physical security exercise each month.

(6) By presenting a physical security briefing at the monthly medical commanders conference conducted by this headquarters.

[illegible] II

C[illegible]

9. (U) Operations. a. The advance party of a unit destined for the Republic of Viet Nam should arrive approximately 30 days prior to the main body. This would allow time for coordinating plans for arrival of the main body, obtaining local directives under which the unit will operate, getting acquainted with higher and lateral headquarters, assuring that land is made available and properly laid out, obtaining self-help material, and arranging for logistical support including Engineer and Signal.

This would make for a smoother reception, location, and establishment of the entire unit.

b. Because of the conditions of war in RVN making every unit installation highly susceptible to guerilla attack and because of the emphasis of physical security placed by higher headquarters, it appears that a full time physical security officer should be assigned to Group Headquarters. This problem is now being studied at this headquarters, and if results justify, a MTOE change will be submitted. The Group Physical Security Officer would be responsible for the security of Group Headquarters and for inspecting physical security plans and defensive measures of subordinate units.

c. To command and control assigned units throughout a widely dispersed area, as was the case in Viet Nam, is a difficult task for a Medical Battalion Headquarters which was the only command and control unit in Corps tactical zones III and IV in Viet Nam during the period May 1965 to February 1966.

Sufficient medical command and control units should be deployed initially to avoid assigning excessive numbers of units widely dispersed to a single headquarters. During 1965 medical units arrived more rapidly than did command and control headquarters.

10. (U) Personnel. Operating under a combat service support role has shown a deficiency in personnel allocations under TOE 8-122E. Although the 68th Med Gp has assumed the role of consolidation of all medical reports and statistics from subordinate treatment facilities, the TOE makes no provisions for Medical Records personnel, MOS 71G. In addition, this unit has the responsibility for monitoring the medical supply functions of subordinate units. The TOE provides for a Medical Supply Specialist, grade E-4, MOS 76J20, however this is unrealistic since several subordinate units have Medical Supply Sergeants in the grade of E-7. A modification TOE has been submitted requesting addition of a Medical Records NCO, grade E-6, MOS 71G40, and a Medical Supply Sergeant, grade E-7, MOS 76J40.

It is recommended that TOE 8-122 be augmented to provide those positions and that augmentations be filled prior to deployment to a combat area.

b. Due to the large number of patients requiring special diets in Evacuation and Field Hospitals, recommend that a Dietician be assigned to RVN in the capacity as a consultant to all hospital units. Recommend also that cooks trained in dietary cooking be assigned by TOE to each hospital.

c. In the area of equipment maintenance, emphasis has been placed on commander and operator responsibilities. Since this Group Headquarters is not authorized technically qualified personnel to inspect and assist units, we have had to rely upon direct support technical maintenance team to perform these duties. To provide a built in capability for control, supervision and training of assigned and attached units, recommend that maintenance section similar to that authorized in para 06, TOE 8-128H, Headquarters and Headquarters Detachment, Medical Battalion, be authorized in TOE 8-142, Headquarters and Headquarters Detachment, Medical Group.

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d. Many difficulties have been encountered due to lack of adequate electrical construction material and insufficient generator power. In the 93rd Evacuation Hospital, inferior locally procured wire fixtures and outlets were installed in the buildings. These installations have been unsatisfactory, resulting in overloaded circuits and short life of light bulbs and fluorescent light ballasts. These power outages could also create a critical situation in the operating room or patient treatment areas. Engineers are replacing the present wiring system as material becomes available.

Power generators organic to hospital TOE's are inadequate to operate additional medical equipment, refrigeration and air conditioning or circulating fans required in this climate.

Recommend that installation of an acceptable wiring system and increased generator capacity be included in early phase of each hospital construction program.

e. Newly arrived medical units have experienced difficulties in obtaining refrigeration required to store biological and blood and for food service operations. Organic refrigeration is inadequate for operation in this climate. In-country authorizations provide sufficient refrigration, however supply agencies have only responded to demands after command pressure has been exercised.

Medical treatment facilities require air conditioning for critical areas such as operating rooms, laboratories and wards. Available air conditioners are not always adequate to needs of the units.

Recommend plans be developed whereby refrigeration and air conditioning for hospitals units be installed prior to the time the hospital becomes operational.

f. Prior to the arrival of the organization, the advance party requested all office furniture and TA equipment on 25 January 1966, using priority 05. As of this report only two or three items have been received. Shortage of adequate file cabinets for classified documents and office machines to compile statistical reports have hindered this units normal operations.

According to supporting logistical units, 02 and 05 priorities have been passed to their supporting logistical activities without recording demand at local level. As a result, 12 and 17 priorities may be available and insured prior to the time the material requested on 02 or 05 priority is received.

Recommend procedures be reviewed and changes be initiated to assure that realistic priorities are assigned to requests and that material is insured according to assigned priority.

g. Incoming hospital units usually arrive with 15 to 50 assigned female nurses. In the past, accommodations for these nurses has been very austere. Living conditions are crowded, shower facilities are limited, household furnishings are inadequate and recreational areas are non existant in many cases.

Recommend that semi-permanent buildings, having facilities and showers be erected and available for occupancy upon arrival of female personnel in-country. Additional items such as wardrobes and dressers should also be available for immediate issue upon arrival of the unit.

11. (U) Communications. Because of the fixed location of group headquarters, TOE communications available is not adequate to reach the combat brigades's or division's clearing stations which many times operate past the range capability of TOE radios.

Recommend three radios of at least 100 mile range capability be provided Group headquarters for adequate communication with combat unit clearing stations. Three radios will provide ability to maintain liaison with two clearing stations simultaneously.

MTOE has been submitted to provide for the additional communications.

12. (U) Logistics. At the present time there is an imbalance between equipment authorized by TOE and equipment required to accomplish assigned mission. In the case of the 3rd Field Hospital and the 17th Field Hospital, much of the TOE equipment is excess to the units present mission since these units occupy permanent structures in Saigon and are equipped with station type property as well as certain items from the assembly. The rest of the TOE items are being stored in CONEX containers, loaned, hand receipted, or laterally transferred to other medical units.

On the other hand, all medical units require additional equipment to accomplish their assigned mission which is in excess of normal TOE mission. Procedure for authorizing equipment under USARV Reg 40-30 require that each separate item be justified. This generates a tremendous administrative load and delays receipt of needed equipment.

Recommend that commanders of medical facilities in permanent or semi-permanent situations be permitted to request required equipment and supplies as authorized in para 7, AR 40-61.

SUB-SECTION II

LESSONS LEARNED

13. (U) a. Item: Mobility of Surgical Hospitals, (Mobile Army)
DISCUSSION: In most cases casualties are picked up from medical units in direct support of combat troops and evacuated by air to hospitals located at fixed locations. This is peculiar to this area where combat units operate from a "base camp". However, at times the operational area is too far, from a time-distance factor, to evacuate the casualty to a fixed hospital site.
OBSERVATION: Surgical hospitals (Mobile Army) should remain mobile in order to relocate near the operational area to better support combat operations. The lesson learned here was that a surgical hospital should be kept mobile even though operating from a "base camp".

b. Personnel. Item: Necessity for addition of a Medical Records NCO, MOS 71G40, grade E-6, and a Medical Supply Sergeant, MOS 76J40, grade E-7, to TOE 8-122.

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DISCUSSION: Operation in a combat support area poses two additional areas of responsibility upon a Medical Group normally not required in a garrison support role. These additional roles are: Consolidation of Medical records and reports and monitoring the medical supply functions of subordinate medical treatment facilities. TOE 8-122E makes no provision for medical records personnel and provides only one E-4, Medical Supply Specialist, MOS 76J20.
OBSERVATION: Experience has shown that there is a definite requirement for a Medical Records NCO, grade E-6 and a Medical Supply Sergeant, grade E-7 in the Headquarters of a Medical Group. TOE 8-122E should be changed to include personnel allocations for those positions.

c. Item: Self-Help Construction

DISCUSSION: Upon arrival in country, units moving into permanent or semi-permanent field locations are required to construct floors and tent frames on a self-help basis. Since most units do not have qualified carpenters or tools, considerable time, effort and material is unnecessarily expended to provide satisfactory operational and billet areas. Assistance to incoming units should include:

(1) Plans and drawings of self-help projects be provided to unit.
(2) Bill of material be provided unit.
(3) Technical engineer assistance be given to unit during initial construction phase.
(4) That suitable lumber (new or usable dunnage) and nails be stocked and made readily available for incoming units.
(5) That power tools be brought with the unit or made available upon arrival in country.

OBSERVATION: Prior to departure from CONUS, units should develop plans for semi-permanent locations upon arrival in country. They should also augment their TAT MED equipment with certain hard to get items such as light fixtures, electric outlets, and plumbing fixtures as well as other items with which they can improvise and improve their living conditions.

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